DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5172

FILED MAR 14 1946

Registration District No. 13 Primary Registration District No. 5430 Registrar's No.

1. PLACE OF DEATH:

(a) County FRANKLIN

(b) City or town RURAL - CENTRAL
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 6 Mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County FRANKLIN 36

(c) City or town RURAL 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rt. 2, UNION Mo. 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME IDA MARIE FISCHER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife GEO. W FISCHER

6. (c) Age of husband or wife if alive years

7. Birth date of deceased AUG. (Month) 8 (Day) 1879 (Year)

8. AGE: Years 67 Months 6 Days 3 If less than one day hr. min.

9. Birthplace NEW HAVEN (City, town, or county) Mo (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business HOME

FATHER 12. Name HENRY FRIES

13. Birthplace (City, town, or county) GERMANY (State or foreign country)

MOTHER 14. Maiden name HANNAH FELIUS

15. Birthplace (City, town, or county) GERMANY (State or foreign country)

16. (a) Informant ALVIN FISCHER

(b) Address Rt. 2, UNION, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 13 1946 (Month) (Day) (Year)

(c) Place: burial or cremation ROBERTSVILLE, MO

18. (a) Signature of funeral director Clay & Lenox

(b) Address St. CLAIR, MO

19. (a) 2-12-1946 (Date received local registrar) (b) E. L. Worthington (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1946 hour 10 minute M.

21. I hereby certify that I attended the deceased from 1-29, 1946, to 2-11, 1946 that I last saw her alive on 2-10, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arterio sclerosis	
Cardio vascular disease	2 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature B. L. Stuehlmann (M. D. or other) M.D.

Address Union, Mo Date signed 2-12-46

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9
District File Number
Date Filed 3-13-46

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by
, Registered Apprentice No.
working under my personal supervision.

Signed H. M. Lenot
Licensed Embalmer No. 3601
P. O. Address St. Clair, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

o. 2B
-3-45
X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mars

Registration District No. 113 Primary Registration District No. 5430 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ida M. Fischer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug 8 1871
(Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) MO (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb day 11th year 1946 hour 8 minute 45 A M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature B G Strehlmann (M. D. or other) M.D.

Address Union, Mo Date signed

4170

5172